

## STARK DECRIES LACK OF CMS OVERSIGHT, EXCESSIVE COST-SHARING IN PART D PLANS

Wednesday, 12 November 2008

Rep. Pete Stark today sent the following letter to Centers for Medicare and Medicaid Services (CMS) Acting Administrator Kerry Weems. The letter admonishes CMS for recent OIG reports that expose an astonishing lack of oversight over Part D plans.

FOR IMMEDIATE RELEASE, Tuesday, November 13th, 2008

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WASHINGTON, DC – Rep. Pete Stark (D-CA), Chairman of the Ways and Means Health Subcommittee, today sent the following letter to Centers for Medicare and Medicaid Services (CMS) Acting Administrator Kerry Weems. The letter admonishes CMS for recent OIG reports that expose an astonishing lack of oversight over Part D plans. The letter also expresses concern with changes in the types of cost sharing under many Part D plans, which places unfair risk on Medicare beneficiaries.

The  
text of the letter follows. The letter is also available [here](#).

November 13, 2008

Kerry N. Weems

Acting Administrator

Centers for Medicare & Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, S.W., Room 445-G

Washington, DC 20201

Dear Mr. Weems:

On the eve of open enrollment for Medicare Part D plans, I am extremely disturbed by a series of reports recently released by the Health and Human Services Office of the Inspector General (OIG). These reports detail rampant abuse by plan sponsors and an inexcusable lack of oversight or accountability by the Centers for Medicare and Medicaid Services (CMS), in dereliction of its statutorily-mandated duty. I have been astonished as the alarming reports of the past weeks literally “just keep coming.”

On November 7, 2008, the OIG released a report revealing that as of April 2008, only 4 percent of 2006 audits of Part D plan bids had begun (even though the law requires an audit of one-third of plan sponsors.) Of those audits that actually are completed, one-fourth exhibit some “material problem.” Despite this high rate of noncompliance, CMS takes no action whatsoever to sanction any plans that submit incorrect bids, such as failing to adjust bid amounts, beneficiary premiums, or payments to plan sponsors.

I was struck by an overwhelming sense of déjà-vu, since the findings of this report were almost verbatim restatements of the July 2007 Government Accountability Office (GAO) report entitled, “Medicare Advantage: Required Audits of Limited Value.” Not only was the language the same, but the excuses offered by CMS were identical to those of over a year ago. As in July 2007, you state that you agree that CMS should fulfill its statutory duty and that it “should consider” taking compliance or enforcement actions against plans that submit incorrect bids. Given the consistency of your agency’s inaction, however, I can only surmise that your actual consideration is to run out the clock on this Administration without ever complying with the minimal oversight requirements Congress put in place to check private plans.

This underwhelming approach to administrative duties and statutorily mandated oversight requirements has quite obviously resulted in a program that operates purely at the whims of private insurance plans – with little regard for protection of beneficiaries or the American taxpayer, as evidenced by two additional OIG reports that detail the abuses that such oversight would prevent in a properly managed agency.

I am also very concerned about several aspects of cost sharing under Part D plan formularies that CMS has approved for the 2009 plan year.

#### - Specialty

Drug Cost Sharing. I am extremely concerned about cost sharing requirements for “specialty drugs” under some plans. A few plans appear

to be charging 50% cost sharing for certain specialty drugs. A beneficiary enrolled in this plan could owe thousands of dollars for one dose. I am concerned that plans are using excessive co-pays to avoid attracting beneficiaries to their plans. Has CMS approved any plans with co-insurance on a specialty drug tier in excess of 25% and when cost sharing for all of the other tiers is lower? If so, please explain in writing why these plans are not in violation of Section 1860D-11(e)(2)(D)(ii) which states that a plan should be disapproved if the "design of the plan and its benefits (including any formulary and tiered formulary structure) are likely to substantially discourage enrollment by certain part D eligible beneficiaries under the plan."

- Penalties

for Using Brand Name Drugs. I have also learned that some plans are charging beneficiaries a penalty if they purchase a brand name drug when a generic is available, above and beyond the established co-pays. I understand that this is happening even for some drugs within the protected classes. Enrollees using these medications must pay the standard co-pay for drugs on that tier plus a penalty equal to the difference between the cost of the brand name drug and the generic drug. While I certainly support the goal of increasing generic utilization, there may be instances where beneficiaries need a brand name drug rather than a generic equivalent. Also, I think Part D coverage is confusing enough without plans continually adding more complexity to this benefit. I am concerned that beneficiaries could find themselves paying far more out-of pocket than they expected. I understand from beneficiary advocates that the plan finder on [www.Medicare.gov](http://www.Medicare.gov) does not take the penalties into account when comparing plans so beneficiaries who plug in the penalty drugs are given highly erroneous information on which to make comparisons. CMS needs to make sure that beneficiaries are aware of these penalties before they choose their plans.

Please

respond to the following questions in writing: (a) do the penalties paid by the beneficiary count towards the calculation of the true out-of-pocket expenses (TrOOP)? (b) Are plans that are imposing these requirements educating providers about these rules? (c) What cost sharing would a beneficiary pay if they win an exception for a non-formulary drug; i.e., is the non-formulary drug subject to the "penalty"? (d) Are low-income subsidy eligible beneficiaries subject to these penalties? (e) Under what authority is CMS using to approve plans with this type of cost sharing structure?

I remain

very concerned about the increase in cost sharing under Part D for drugs and whether plans are truly getting the best deal for taxpayers. Some of the changes that are needed to control costs in this program require statutory changes, and I remain committed to enacting legislation that will address these problems. In the meantime, I believe that CMS could better use the bidding process to stop approving plans that appear to place unfair risk on the Medicare beneficiary population.

Sincerely,

Pete Stark

Chairman

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